

Redesigning Medicaid Health Care in New York State

The Medicaid Redesign Team (MRT) was tasked by Governor Cuomo to find ways to



reduce costs and increase quality and efficiency in the Medicaid program. The MRT is addressing the realities that our State spends more than twice the

national average on Medicaid per person, and spending per enrollee is the second highest in the nation. At the same time, New York ranks 21st out of all states for overall health system quality and ranks last among all states for avoidable hospital use and costs.

The work of the MRT affects the system of care directed by the Office of Mental Health (OMH), because like most states, New York uses Medicaid to pay for almost all mental health care, even that which once was wholly a State responsibility. So changes in Medicaid mean changes in mental health care. Less spending and wiser use of resources set the direction for Medicaid redesign.

For New York State (NYS), improving service efficiency and effectiveness presents opportunities. The specialty mental health system overseen by OMH requires a big safety net. This is due mostly to a systematic failure to address mental health problems in the general health system, where most of us go when we need help. Data show, for example, that although the average age of first mental health symptoms is 13, the average delay until getting care is nine years. Such a delay in general medical care would be unacceptable. Moreover, only about one-half of all physicians report feeling comfortable with diagnosing and treating depression, the most common and reliably

Two major developments will disrupt our lives, affecting almost everyone who receives services or works in our vast system. Both of these developments (Medicaid Redesign and the most challenging budget in years) will force change, upset the status quo, and force us to think hard about priorities. There's nowhere to hide from these realities. My view is that we have to engage, adjust and adapt.

*Commissioner Hogan
January 2011*

diagnosed mental illness. The weakness in care for mental health problems exists across the general health system from primary care to health plans.

One provision of the Affordable Care Act (ACA) this year illustrates how changes in Medicaid affect the delivery of local health care. Under the ACA, states now have the option under their individual Medicaid State plan to receive additional federal reimbursement for the enhanced integration and coordination of care for people with chronic illnesses, across the lifespan. The goal is better integrated primary, acute, behavioral health (mental health and substance use), and long-term services and supports.

To address the realities of Medicaid spending and opportunities to realign services to be more efficient, the MRT is following a two-phase approach to drive efficiencies that lead to improvements in quality, safety, and effectiveness of patient care:

- Phase 1: The primary goals included the establishment of the MRT to find solutions for lowering Medicaid costs in the 2011–12 State fiscal year budget, without compromising care for New Yorkers, and to develop a set of recommendations for the Governor’s consideration and approval.
- Phase 2: The major goal of this phase calls on the MRT to create a coordinated plan to ensure that the Medicaid program functions within a multi-year spending limit, while sustaining and improving the quality of services delivered.

Phase 1 of Medicaid Redesign: Setting the Foundation

Beginning in January 2011, upon appointment of the MRT, the Team held public forums and sought reform ideas from health experts and diverse shareholders from every region of our State. From the more than 4,000 suggestions made by New Yorkers, the MRT reviewed, synthesized and prioritized reform proposals into a single package of recommendations to Governor Cuomo.

Through legislative approval, the resulting proposals in the budget bill introduced structural reforms that helped the State to achieve its current fiscal year Medicaid budget target, without cuts to eligibility. The implementation of proposals ([descriptions of the MRT proposals](#)) began an orderly shift in redesign of the Medicaid payment system in the State to one oriented toward better outcomes and quality care.

Specifically, major elements of reform undertaken in Phase 1 included:¹

1. Effecting a three-year phase in of “care management for all” Medicaid beneficiaries and ending fee-for-service (FFS) payment arrangements
2. Planning for the expansion of patient-centered medical homes, launching health homes, and enrolling Medicaid beneficiaries in these care management models
3. Initiating development of regional behavioral health organizations (BHOs) to meet the goal of full integration of physical and behavioral care within innovative care management arrangements (see glossary of common terms being used in relation to Medicaid redesign in Figure 1).
4. Enacting a “global Medicaid cap” that links growth to the medical consumer price index, challenges providers to control costs, and requires monthly reporting of Medicaid spending compared to projected State fund expenditures

Figure 1
Innovative Health Care Management and Service Delivery Models Glossary

Managed care describes a health insurance plan or health care system that coordinates the provision, quality, and cost of care for its enrolled members. Each managed care enrollee selects a primary care practitioner from the plan's network of professional and hospital providers. A primary care practitioner holds responsibility for coordinating an enrollee's health care and making referrals for specialty care. There are many different types of Medicaid managed care funded in the State (e.g., Medicaid managed care, Family Health Plus, Medicare Advantage) serving residents in all age groups and various income levels.²

An **accountable care organization (ACO)** represents a local health care organization and collaborating primary care physicians and other health providers, specialists and hospitals that are held accountable for the cost and quality of care delivered to a defined population of individuals. The performance of the ACO is linked to financial incentives or penalties based on valid and reliable measures of individual- and system-level outcomes.³

An **integrated delivery system (IDS)** is a well-structured, coordinated, and collaborative network of organizations (e.g., Kaiser Permanente) that either provide or arrange provision of a continuum of services to a defined population or community. The IDS is accountable clinically and fiscally for the health outcomes of the population or community served.⁴

A **special needs plan (SNP)** model of care management provides clinical service planning, service acquisition, service delivery and coordination by a designated medical case manager and/or case management team. SNP services (currently available to individuals with HIV in NYS who receive Medicaid) are client-centered and promote timely, coordinated access to medically appropriate levels of care and services that support engagement in care and wellness through education, care advocacy, and health promotion.⁵

Behavioral health organizations (BHOs) are administrative entities in New York State that will assist regionally in the management of behavioral health services for individuals not enrolled in managed care for their behavioral health services and for those whose services are not covered by a Medicaid managed care plan, regardless of whether a person is enrolled in a managed care plan that includes behavioral health services or not. Chief activities during the three-year transition to care management for all Medicaid beneficiaries will be assessing the use of behavioral inpatient care and reducing readmission rates, monitoring and contributing to understanding conditions of children diagnosed with serious emotional disturbance and treated in OMH-licensed clinics, monitoring key performance indicators, and facilitating linkages across systems of care.⁶

A **patient-centered medical home (PCMH)** is a model for care, provided by physician-led practices, that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and individual's complaints with coordinated care for all life stages, acute, chronic, preventive, and end of life, and a long-term therapeutic relationship. The physician-led care team is responsible for coordinating all of the individual's health care needs, and arranges for appropriate care with other qualified physicians and support services.⁷

The **health home** model expands on the traditional patient-centered medical home concept. The health home is a provider or team of health care professionals who provide integrated care based on a "whole-person"

philosophy where care is provided to meet physical, emotional, behavioral, social, family and community needs. A health home further enhances the integration and coordination of medical and behavioral health care for people who are living with multiple chronic illnesses and includes links to other essential community and social supports that foster healthy, productive community living.^{8,9} A variation of the health home for people with serious mental illness that could emerge is the behavioral health home described below.

The **behavioral health home** could be modeled after the patient-centered medical home to address the distinct behavioral and health care needs of individuals with serious mental illnesses/substance abuse disorders and reduce the likelihood that they will fall through the cracks. Particular attention is paid coordinating and integrating health care that fosters a consistent relationship with the primary clinician, a single care plan where changes are clearly communicated to others providing care, post-hospital discharge services that emphasize continuity of care in the community, and intensive outreach to individuals who stop participating in care.¹⁰

Within three years, all Medicaid beneficiaries will be in some form of managed care in our State. The implementation of care management for Medicaid beneficiaries by the end of 2013 or early 2014 clearly impacts the strategic directions of OMH and the Office of Alcoholism and Substance Abuse Services (OASAS). Among the proposals receiving the intense focus of the two agencies are one calling for the implementation of “health homes” for Medicaid beneficiaries who have high health care needs and costs, and another, Number 93, which requires the development of an interim managed FFS model, known as regional BHOs, which will help to bridge the transition to managed care for people who receive behavioral health services not “covered” under the State’s existing various Medicaid managed care plans. The goals are to improve the coordination of care between services and across service systems, strengthen accountability for care, reduce unnecessary behavioral health and physical inpatient care, and enhance discharge planning to avoid preventable readmissions to inpatient care.

Together, the two proposals have been described somewhat like a two-stage rocket. Movement toward managed care arrangements for Medicaid beneficiaries identified as “high-need, high-cost” builds on both proposals, with one atop the other and launched in succession. The Phase 1 regional BHO model that makes up the first stage is jettisoned, while the Phase 2 cabin of the rocket—the health home initiative—continues on its mission. The jettisoned behavioral health organization structure, however, is conserved, “re-conditioned” and reused for Phase 2. The phased launch is designed to help individuals with complex behavioral conditions reach the highest level of integrated physical and behavioral health care and full, productive community living.

Behavioral Health Organizations

The concept of the BHO and the creation of regional BHOs build on the experience of the New York City–State care monitoring initiative.¹¹ The development of BHOs represents the next natural step in moving the statewide system toward enhanced recovery-focused accountability and reduced system fragmentation.

As part of the first phase of the BHO initiative (not to be confused with the first phase of the MRT), OMH and OASAS met with stakeholders, delineated major BHO functions, and formed a preliminary time line for implementation. In late June, the agencies jointly released a

request for proposals to seek applications for the provision of Medicaid FFS administrative and management services in five regions of the State (see Figure 6) aimed at concurrent review of inpatient behavioral health services and the coordination of behavioral health services.

Figure 6: BHO Regions



BHOs will assist recipients, providers, families and localities across five regions of the State to prepare for the transition from the current unmanaged FFS to a managed behavioral health services environment. Essentially, OMH and OASAS will contract with the BHOs and, in conjunction with local governmental units, all will work together toward successful implementation.

Specifically, BHOs will aid in the management of behavioral health services for individuals whose services are currently covered under the FFS

system. The major functions of BHOs during Phase 1 include:

- Monitoring behavioral health inpatient length of stay
- Reducing unnecessary behavioral health inpatient hospital days
- Reducing behavioral health inpatient readmission rates
- Improving rates of engagement in outpatient treatment following discharge from inpatient care
- Adding to our understanding the clinical conditions of children diagnosed as having a serious emotional disturbance
- Monitoring provider performance
- Testing metrics for assessing system performance

BHOs have been tasked with adding to our understanding of the clinical conditions of children diagnosed as having a serious emotional disturbance to help achieve the goal of having all Medicaid recipients receive managed services by the end of three years. As such BHOs will monitor OMH-licensed specialty clinics to determine when children in Medicaid managed care are diagnosed with serious emotional disturbance and to capture clinical characteristics to aid planning. In this first phase of activity, while health homes may not exclude children, the focus will be on better understanding the characteristics of children who are already enrolled in managed care and are diagnosed as having serious emotional disturbance. The data will help to shed light on how care management can be arranged for children and families to meet their unique needs.

Phase I also provides OMH and OASAS with the opportunity to test and evaluate various systems metrics—those relevant and quantifiable attributes of BHO system performance over time—to monitor quality and identify trends. The initial set of metrics centers on measures of access to and appropriateness of services, engagement in treatment and continuity of care, and acceptability of care. Within each of these three domains, the following performance expectations will be used with a defined set of performance indicators, which may be modified or expanded by OMH and OASAS as indicated:

- **Access.** Access to appropriate behavioral health services will be maintained as managed care strategies are implemented (e.g., metrics focus on outpatient, and inpatient and emergency services).
- **Engagement and Continuity.** Individuals who have been ill enough to be hospitalized will be engaged in appropriate follow-up services promptly upon discharge (e.g., metrics focus on time from discharge to outpatient/non-crisis service visits, confirmation of post-discharge outpatient appointments documented in plan of care, outpatient visits completed over a defined period, re-engagement in appropriate level of care such as assertive community treatment following hospitalization, prescriptions filled and re-filled post-discharge, receipt of physical health services as prescribed).
 - Inpatient length of stay will be of appropriate duration (e.g., metrics focus on mean days, proportion of long stays).
 - Readmission rates will decline (e.g., metrics focus on 30- and 90-day readmission rates).
- **Acceptability.** Post-discharge persons will be referred to services offered by providers that individuals find useful enough to come back a second time (e.g., metrics focus on second appointments kept, prescriptions filled).

To foster quality care, each regional BHO will share aggregate information on provider patterns of care with local governmental units, as well as with stakeholders that include physical and mental health and substance abuse providers, insurers, consumer groups, family groups, health homes and other appropriate organizations in the BHO region.

Upon completion of the review of requests for proposals, OMH and OASAS in September announced notice of conditional awards for the BHOs. Implementation of Phase I is targeted to begin on October 1, with all regional BHOs scheduled to be fully operational by January 1, 2012.

Phase 2 of Medicaid Design: Toward Comprehensive Reform

As part of the MRT Phase 2 activities, work is under way to develop specialized, comprehensive care plans capable of managing behavioral and physical health services for individuals who have considerable behavioral and physical health needs. The specific populations of individuals who receive Medicaid in New York State are described in Figure 2.

Figure 2
Populations Served by Medicaid Health Care in New York State

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| <p>1. People who receive Temporary Assistance to Needy Families (TANF) and Home Relief (“Safety Net”) recipients. TANF and Home Relief recipients voluntarily or mandatorily enrolled in Medicaid managed care are assigned to comprehensive managed care plans. Behavioral health benefits include inpatient psychiatric and mental health clinic services. Children identified as having a serious emotional disturbance (SED) and served by OMH-licensed specialty clinics receive clinic services on an FFS basis. In addition, mental health services in OMH-licensed outpatient programs other than clinics, continuing day treatment, intensive partial rehabilitative treatment, children’s day treatment and partial hospitalization are not covered by Medicaid managed care.</p> <p>2. People who receive Supplemental Security Income (SSI) are assigned to “health only” Medicaid managed care plans. Currently, people who receive SSI and most children in foster care in New York City do not receive any mental health services through mainstream Medicaid managed care plans.</p> | <p>3. People who are enrolled in Medicaid and Medicare have dual coverage and are not covered under Medicaid managed care and are excluded from this care management process for the initial term of the contract.</p> <p>4. All other persons NOT enrolled in Medicaid managed care might include people living in smaller counties who have been exempted from mandatory enrollment in Medicaid managed care, children in foster care, people who are homeless and people identified as having serious mental illness. Behavioral health inpatient admissions for these individuals are FFS.</p> <p>Medicaid managed care plans cover inpatient rehabilitation services for people not enrolled in SSI and inpatient detoxification (Part 816) services for all enrollees of Medicaid. Many FFS claims are paid for detoxification services provided to individuals not enrolled in Medicaid managed care; often these individuals are not enrolled in Medicaid managed care because they meet exemption criteria.</p> |
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In Phase 2, all care for people with serious mental illness will be managed in each region by one of three options: integrated delivery systems, special needs plans, and behavioral health organizations (see glossary). What’s important about each of these arrangements is that the entities are responsible for the provision of defined health services while working to keep costs in check and to sustain quality care.

To accomplish the MRT goal of developing a multi-year plan for care management that meets the unique needs of Medicaid beneficiaries, the MRT subdivided into several work groups in June. Once the work groups were determined, membership was rounded out to ensure broad stakeholder representation. The work groups are addressing, in a complementary fashion, a series of multifaceted issues carried over from the initial work of the MRT. With the exception of the first work group, which is described here, summaries of the charges of the other active groups are available in Appendix 1 (and also on the MRT website).

Behavioral Health Reform Work Group

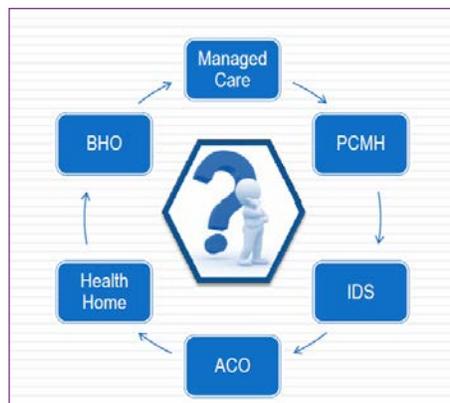
The Behavioral Health Reform Work Group is of utmost importance to the individuals with the most serious behavioral conditions and families served by the public mental health and substance abuse systems of care. Chaired by OMH Commissioner Hogan and Linda Gibbs, Deputy Mayor of Health and Human Services in New York City, the Work Group has been

meeting since June 30, 2011, and slated to complete its final report by October 15. The time line leaves sufficient time for the MRT to consider and submit its recommendations to the Governor for development of the 2012–13 State budget.

The Behavioral Health Reform Work Group is taking this opportunity to examine care management models that best match the needs of individuals and local systems of care within the framework of integrated health and behavioral health where the divide between the mind and body no longer exists.¹² The work group’s three major areas of attention include:

Figure 3: Examining Options for Managing Care

- Considering principles and performance standards for the provision of integrated behavioral and physical health services for likely incorporation into one of three types of Medicaid care management delivery and payment models—integrated delivery system, special needs plan, and behavioral health organization models
- Exploring strategies for improving the integration of behavioral and physical health care, including peer support services, while identifying ways to reduce administrative and regulatory burdens
- Providing guidance to DOH on the implementation of the health homes initiative, which is set this fall to begin enrolling Medicaid beneficiaries



Inherent in efforts to address all three areas is the recognition that while primary care has a significant role in integrated care management strategies, the mental health system has a clear and understandable stake in the design of care management approaches for children, adults and families with serious mental health challenges. The push to streamline care to be more efficient and effective presents an extraordinary opportunity to reshape policy, practice and financing mechanisms and ultimately the way behavioral health care is provided.¹³

An example of how the Behavioral Health Reform Work Group is taking advantage of the opportunity to reshape care and promote recovery is through its examination of proven peer and family support approaches, discussion of the unique contributions that peer and family support providers offer people who are in recovery, and study of peer and family support strategies that protect the integrity and fidelity of the service model, while ensuring the availability of these cost-effective services to individuals and families.

The work group also formed a Children’s Subcommittee of stakeholders in late July to consider a minimum set of behavioral health standards for children that public and private insurance plans ought to meet; admission criteria, benefits under specialty behavioral care for children, medical necessity, and provider network attributes; and key outcome indicators to use in anchoring quality within regular and specialty care plans. The Subcommittee completed its

work by mid-September and submitted its final recommendations to the Behavioral Health Reform Work Group.

In October the work group will present its set of recommendations to the MRT, spelling out steps it advises for the transition to specialty care for people with complex primary care and behavioral health disorders and strategies for systemic changes necessary for successful care coordination and integration (e.g., engaging primary providers in assuming responsibility for behavioral care, ensuring primary and other health services in behavioral health homes). Overall, the recommendations should reflect the commitment of the health care system to meet any health need in an integrated, coordinated fashion.

Health Homes and Care Management for People with Serious Mental Illness

Just how is the health home concept being developed in New York? Who will be assigned to health homes and how what happens to people with complex mental health and physical health needs?

DOH leads the effort in NYS to develop the health home model of care and to partner with OMH and OASAS to ensure appropriate and quality care for individuals with the most complex psychiatric and chemical dependency needs. Health homes, including behavioral health homes, are expected to provide continuous, interdisciplinary medical and behavioral care and social services for people living with chronic conditions. Such services would not necessarily be delivered at one location, but rather they would be the responsibility of a network or team of health care professionals and providers who integrate primary care, behavioral health and other health services that meet the needs of each person served. Health homes are intended to expand the concept of the patient-centered medical home into the community so each person may receive additional support (e.g., assistance in keeping a doctor's appointment) to cope effectively with complex illness and to lead as healthy and full a life as possible. Health homes will help to improve outcomes, reduce unnecessary hospitalization and emergency department use, and diminish long-term care costs.

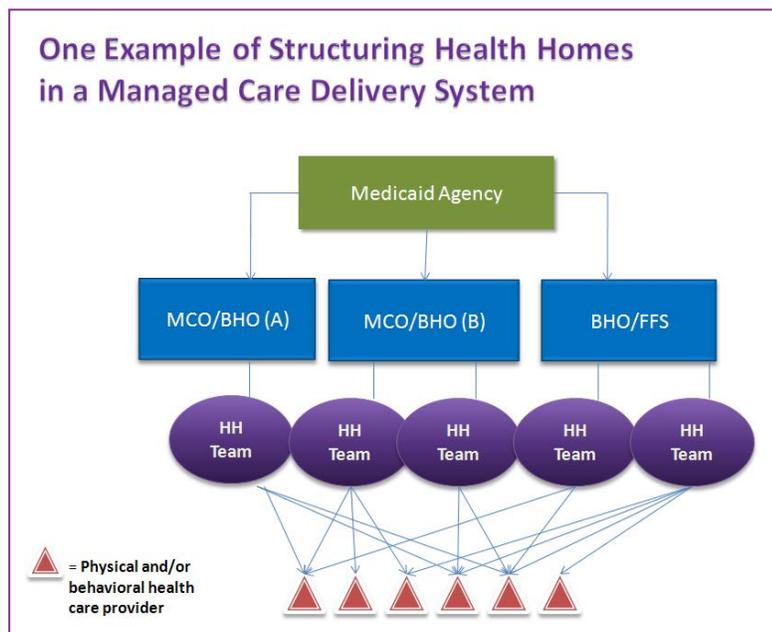
Under the terms of the federal health home initiative, New York and other states must meet specific requirements, such as limiting health home services to Medicaid beneficiaries with at least two chronic conditions, one chronic condition and the risk of another, or one serious mental health condition. One limitation of the law, however, is that beneficiaries of both Medicare and Medicaid may not participate in the initiative. NYS's consultation with the federal Substance Abuse and Mental Health Services Administration, a requirement of states submitting amendments to their federal State Plans, has already taken place.

The goal in NYS is to begin enrollment in health homes for the identified populations this fall. In late September, DOH announced a three-phase implementation plan, with health homes starting in 13 counties as of January 2012; the start of health homes in the remaining counties is anticipated to occur during the last two phases, in April and June 2012.

Planning currently includes a tiered approach to intensity of health home services, with regular assessments of need for continuation in health home services. Homes providing services for people with moderate need (e.g., one chronic condition and at risk for another)

would be the first level, followed by homes for individuals with multiple complex needs, and a third level for people with intensive complex needs, including people with the most serious behavioral health conditions. New Yorkers interested in following the progress of health home implementation may go to the [DOH Medicaid Health Homes Web Page](#) for additional information.

Figure 4: Example of Home Health Structures



The Behavioral Health Reform Work Group, among other responsibilities, is considering recommendations on a number of fronts, but not limited to:

- **The structuring of health homes in managed care delivery systems.** Figure 4 illustrates just one example of a structure, where managed care and behavioral health organizations would each report to the State Medicaid agency and have a series of health home teams where providers of those teams have

an ability to participate flexibly. Whatever structures are developed for organizing health home services, the regional BHOs will be involved in the assignment of Medicaid beneficiaries who qualify for health homes. Moreover, DOH recognizes that health homes and regional management structures composed of the BHO/MCO/Health Home may be necessary.

- **The evaluation of the effectiveness of care management as models form and strive for integrated, coordinated and effective care.** The Work Group is considering necessary performance indicators related to housing, employment, and recovery; the quality of care as measured by the percentage of services based on sound scientific evidence; the provision of prevention services; the continuity of treatment for people who have the greatest clinical and social needs; care coordination across treatment domains; and, importantly, whether disparities are present in access to and the outcomes of care.
- **The need to address the unique characteristic of mental illness: it can impair a person's ability to seek needed help.** The work group is examining lessons learned from the care monitoring initiative in New York City designed to identify at-risk people with high service needs who have become disengaged from and possibly in need of care. The experiences gained from this crucial initiative are helping to set care coordination expectations for outreach and engagement. Among these would be welcoming environments; open scheduling and immediate access to urgent care;

embrace of shared decision-making approaches; peer outreach, wellness coaching and support; peer-operated alternatives; mobile outreach services to reach those unable or not willing to go to a services location; and a regard for the principle of procedural justice to help people be safe.

Wrap Up of MRT Activities

Upon completion of its consideration of work group recommendations, the MRT will provide summary documentation of the approved recommendations from the work groups. Out of the documentation and recommendations and under Governor Cuomo's leadership, the State will advance a comprehensive action plan for true Medicaid reform.

As this Statewide Plan readies for publication and before the MRT wraps up its work, the Behavioral Health Reform Work Group has sought input into recommendations being prepared for the MRT. It urges stakeholder to stay abreast of its ongoing deliberations by visiting its page on the [Medicaid Redesign web site](#).

¹ There are many aspects to the budget bill reform proposals not included in this narrative that are important to the overall success of the Medicaid redesign, but beyond the scope of detailed discussion in this Plan. To learn about the comprehensive package of reforms, the reader is referred to the Medicaid Redesign website at http://www.health.ny.gov/health_care/medicaid/redesign/.

² See the State Department of Health Managed Care page online at http://www.health.ny.gov/health_care/managed_care/index.htm.

³ Devers K & Berenson R. (2009, October). *Can accountable care organizations improve the value of health care by solving the cost and quality quandaries?* Available from the Robert Wood Johnson Foundation at <http://www.rwjf.org/files/research/acosummaryfinal.pdf>.

⁴ Shortell SM, Gillies RR, Anderson DA, et al. (1996). *Remaking health care in America*, San Francisco: Josey-Bass.

⁵ See the New York State Department of Health "HIV Special Needs Plan" page online at <http://www.health.ny.gov/diseases/aids/resources/snps/>.

⁶ New York State Office of Alcoholism and Substance Abuse Services and Office of Mental Health. (2011, June). *Behavioral health organizations selection process document instructions*. Available online at http://www.omh.ny.gov/omhweb/rfp/2011/bho/selection_process_document.pdf.

⁷ See the Health Home Q&As on the New York State Department of Health website at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/2011-08-09_questions_and_answers.htm.

⁸ See "What is a health home," available on the Substance Abuse and Mental Health Administration blog at <http://blog.samhsa.gov/2010/12/04/what-is-a-health-home/>.

⁹ See the Health Home Q&As on the New York State Department of Health website at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/2011-08-09_questions_and_answers.htm.

¹⁰ Smith TE & Sederer LI. (2009). A new kind of homelessness for individuals with serious mental illness? The need for a mental health home. *Psychiatric Services*, 60, 528–533.

¹¹ More information on the Care Monitoring Initiative appears in the January 2010 OMH News available online at <http://www.omh.ny.gov/omhweb/resources/newsltr/2010/jan/#med>.

¹² Strosahl K. (1997). Building primary care behavioral health systems that work: A compass and a horizon. In *Behavioral Health in Primary Care: A Guide for Clinical Integration*, N. Cummings, J. Cummings, and J. Johnson, Eds, pp. 37–58. Madison, CT: Psychosocial Press.

¹³ Collins C, Hewson DL, Munger R et al. (2010). *Evolving models of behavioral health integration in primary care*. New York: Milbank Memorial Fund. Available online at <http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf> .